Patient Intake Form

Patient Information

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex ❍ M ❍ F Marital Status ❍ Single ❍ Married ❍ Widowed ❍ Divorced

Employer _____ Occupation _____

Home Phone _____ Work/Cell Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should we contact?_____ Phone _____

Have you received acupuncture therapy before? ❍ Yes ❍ No

Date of your last treatment? _____ With Whom? _____

Name of your Primary Care Physician _____ Phone _____

Chief Complaint(s)

What is today's chief complaint? _____

_____

Please list your health concerns in order of importance:

1. _____

2. _____

3. _____

What do you believe is causing your most important health concern _____

_____

_____

Have you seen a physician in the past two years? ❍ Yes ❍ No

Personal History

Describe a typical days diet for you:

Breakfast _____

Lunch _____

Dinner _____

Snacks (what hour) _____

Sources and amounts of:

Caffeine (coffee/tea/soda/other) _____

Alcohol _____

Smoking history and amount _____

_____

Exercise (frequency and types) _____

_____

Weight and Height:

	Current	Past year	Past 5 years
Weight			
Height			

Allergies to drugs or food of any kind:

1. _____

2. _____

3. _____

What are your primary sources of stress?

1. _____

2. _____

3. _____

How much do you think they impact your life?

_____

Do you enjoy what you do for a living? ❍ Yes ❍ No

How many hours do you work per week? _____

Number of play/relaxation hours? _____

What is your exercise routine? _____

What do you do to manage stress & take care of yourself?

_____

_____

Date of last physical exam _____

If abnormal, explain _____

_____

Date of last dermatology checkup _____

If abnormal, explain _____

Any personal history of skin cancer? ❍ Yes ❍ No

If over age 50, have you had a colonoscopy? ❍ Yes ❍ No

Date of last colonoscopy _____

Any positive findings on colonoscopy? ❍ Yes ❍ No

If yes, explain _____

Date of last eye exam _____

If abnormal, explain _____

Do you visit the dentist regularly? ❍ Yes ❍ No

If yes, how frequent? _____

Do you have ❍ Dental problems ❍ Gum inflammation ❍ Gingivitis?

If yes, explain _____

Current Illness or Concern

- ❍ Headaches
- ❍ Weight
- ❍ Vision
- ❍ Nose/sinuses (example: allergies, sinus infections)
- ❍ Throat (example: recent or recurrent infections)
- ❍ Digestive tract problems (example: bowel problems, hemorrhoids, hernias, diarrhea, bloating) How often do you have a bowel movement?

  _____
- ❍ Energy
- ❍ Body temperature
- ❍ Other eye problems (infections, sties)
- ❍ Mouth/teeth/gums (including dental procedures)
- ❍ Skin (eczema, infections, rashes)
- ❍ Heart disease (rheumatic fever, shortness of breath, palpitations)
- ❍ Stomach (ulcers, acid reflux, etc)
- ❍ Musculoskeletal concerns (arthritis, joint problems, Osteoporosis, muscle pain, weakness)
- ❍ Other _____

  _____

  _____

  _____

For Women Only

Are you currently experiencing any gynecological problems? ❍ Yes ❍ No

Are you sexually active? ❍ Yes ❍ No

If sexually active, do you practice safe sex? ❍ Yes ❍ No

Any problems related to sexual function? ❍ Yes ❍ No

History of sexually transmitted diseases? ❍ Yes ❍ No

If yes: ❍ Syphilis ❍ HIV ❍ HPV ❍ Chlamydia

❍ Herpes ❍ Genital worts Date of diagnosis _____

Number of pregnancies? ___ Births? ___
Abortions? ___ Miscarriages? ___

How often do you have a gynecological exam and Pap Smear?

_____

Date of last Pap Smear _____

If abnormal, explain _____

Any personal history of cervical cancer? ❍ Yes ❍ No

If yes, when _____

Any personal history of ovarian cancer? ❍ Yes ❍ No

If yes, when _____

Any personal history of breast cancer? ❍ Yes ❍ No

If yes, when _____

Do you perform breast self exams? ❍ Yes ❍ No

If yes, how often? _____

If menopausal or premenopausal list symptoms and/or concerns

_____

_____

_____

Family History

Be sure to include current age or age of death, major illness history, including diabetes, heart disease, hypertension, coronary artery disease, elevated cholesterol levels, stroke, renal disease, arthritis, TB, asthma, lung disease, headache, seizure disorder, mental illness, suicide, alcohol or drug addiction, osteoporosis, cancer, allergies, etc.

Family Member	Living?/Age	Major illness or cause of death
Mother		
Father		
Brother		
Sister		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

Surgeries

Age _____ Description _____

Age _____ Description _____

Age _____ Description _____

Age _____ Description _____